DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

JAN 24 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 41043

Registration District No. 399 — Primary Registration District No. 1002 — Registrar's No. 4723

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH
(a) County: Jackson
(b) City or town: Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: K.C. General Hospital No. 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 2 Mos. & 10 days
In this community: 3 months 0
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson 048
(c) City or town: Kansas City 3
(If outside city or town limits, write "RURAL")
(d) Street No.: 536½ Walnut St.
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME: Albert BEN CORY
3. (b) If veteran, name war: none
3. (c) Social Security No.: None

4. Sex: Male
5. Color or race: W
6. (a) Single, widowed, married, divorced: Single
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: May 6 (Month) 1871 (Day) (Year)

8. AGE: Years: 70 Months: 7 Days: 12 If less than one day: hr. min.

9. Birthplace: (City, town, or county) Ohio (State or foreign country)
10. Usual occupation: Plumber
11. Industry or business:

MOTHER FATHER
12. Name: Wm Henry Cory
13. Birthplace: (City, town, or county) Ohio (State or foreign country)
14. Maiden name: Anna M Wakeman
15. Birthplace: (City, town, or county) Ohio (State or foreign country)

16. (a) Informant: Mary Vance
(b) Address: 615 W 16 st
17. (a) Cremation (Burial, cremation, or removal) (b) Date thereof: Dec 20-1941 (Month) (Day) (Year)
(c) Place: burial or cremation: Cremation Elmwood
18. (a) Signature of funeral director: Mrs C R Foster
(b) Address: 918 Brooklyn
19. (a) 12-19-41 (Date received by local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Dec. day: 18th year: 1941 hour: 3 minute: 20 P. M.

21. I hereby certify that I attended the deceased from 10-8-41, 19 to 12-18-41, 19; that I last saw him alive on 12-18-41, 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Hypostatic bronchopneumonia	
Due to: Intertrochanteric fracture left femur due to accidental fall in home	1
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy: See above	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify):
(b) Date of occurrence: 12 3
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury: 0

23. Signature: Wm R Thom (M. D. or other)
Address: Med Dir. K. C. Gen. Hospital Date signed:

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, ~~or by~~ .....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Theron A Redmon

Licensed Embalmer No. 2737

P. O. Address R. C. mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

V. S. No. 2B
0M—8-21-41
I X29288

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MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41643

Registration District No. 399 Primary Registration District No. 1002 Registrar's No.

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Albert B. Cory
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased May (Month) 6 (Day) 1871 (Year)

8. AGE: Years 70 Months 7 Days 12 If less than one day hr. min.

9. Birthplace Ohio. (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business

MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month day year hour minute M.
21. I hereby certify that I attended the deceased from 19 to 19;
that I last saw h alive on 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to Intertrochanteric fracture left femur.	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause to which death should be charged statistically.

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22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence 10-8-41
(c) Where did injury occur? At his home (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature Jerry R Sloan (M. D. or other)
Address Med. Dir. K. C. Gen. Hospital Date signed

S-41043